Massachusetts Leads the Way: Pay for Performance to Reduce Racial/Ethnic Disparities

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Introduction

- Disparities in health and health care continue to exist
- “Pay for Performance” (P4P) has become increasingly common among both private and public payers
- Until now, P4P has not been utilized to reduce disparities in performance between racial-ethnic groups

Pay-for-Performance and Disparities

Pay-for-Performance (of P4P) is the practice of rewarding providers to meet quality goals and to improve outcomes of care, rather than paying for the volume of services they provide.

Questions have been raised about potential impact of P4P on racial-ethnic disparities

Research Questions

- Why and how was the MassHealth P4P/disparities program developed?
- How has the program been implemented?
- What are lessons learned?

Methods

- Review public documents
- Interview staff at Massachusetts' Executive Office of Health and Human Services (Office of Medicaid), which was responsible for the P4P/disparities program.
- Analyze hospital performance data
- Speak to members of the hospital community about their experiences with the program.

Chapter 58-The Massachusetts Universal Health Care Law Also Mandated Hospital P4P

- Institute of Medicine's Unequal Treatment in 2003
- Boston Task Force to Eliminate Racial and Ethnic Disparities (2004-5)
- State Commission to End Racial and Ethnic Disparities – Report (2007)
- Section 25 of Chapter 58 (2006)
  - MassHealth hospital rate increases contingent on quality standards, ***including the reduction of racial and ethnic disparities***.

P4P Measures

1) Clinical Measures - Reward Hospitals to report data by Race/Ethnicity & to reduce differences in clinical processes
2) Structural Measures - Reward Hospitals to improve organizational factors that may reduce racial/ethnic health disparities.

Clinical P4P Measures

1) Maternity/Newborn indicators
2) Pediatric Asthma indicators
3) Pneumonia indicators
4) Surgical Infxn Prevention indicators

Criteria for Selection:

- ***Office of Medicaid***
  - ***Relevant*** **(high impact on population)**
  - ***Actionable*** **(scientifically sound; within provider control)**
  - ***Feasible*** **(existing technical specs, minimized collection burden, sufficient volume)**
- **NQF -- evidence of a quality gap**

Structural Measures: Implementing CLAS – The CCOSA* (Selected Domains and Items)

HOSPITAL GOVERNANCE POLICY

Board adopted mission statement articulating cultural diversity as core value.

Board and senior management reflect the racial and ethnic mix of the actual population mix being served.

ADMINISTRATION & MANAGEMENT POLICY

Hospital provides diversity training for all clinical and nonclinical staff.

Hospital patient data is analyzed by race, ethnicity, and languages spoken.

SERVICE DELIVERY POLICY

Policies exist to include R/E communities in planning/design of services.

Hospital interpreter skill requirements are based on nationally recognized professional medical interpreter association standards.

CUSTOMER RELATIONS POLICY

Patient-satisfaction surveys are translated for non-English-speaking patients.

Interagency collaborative projects exist in racial/ethnic neighborhood communities in your service area.

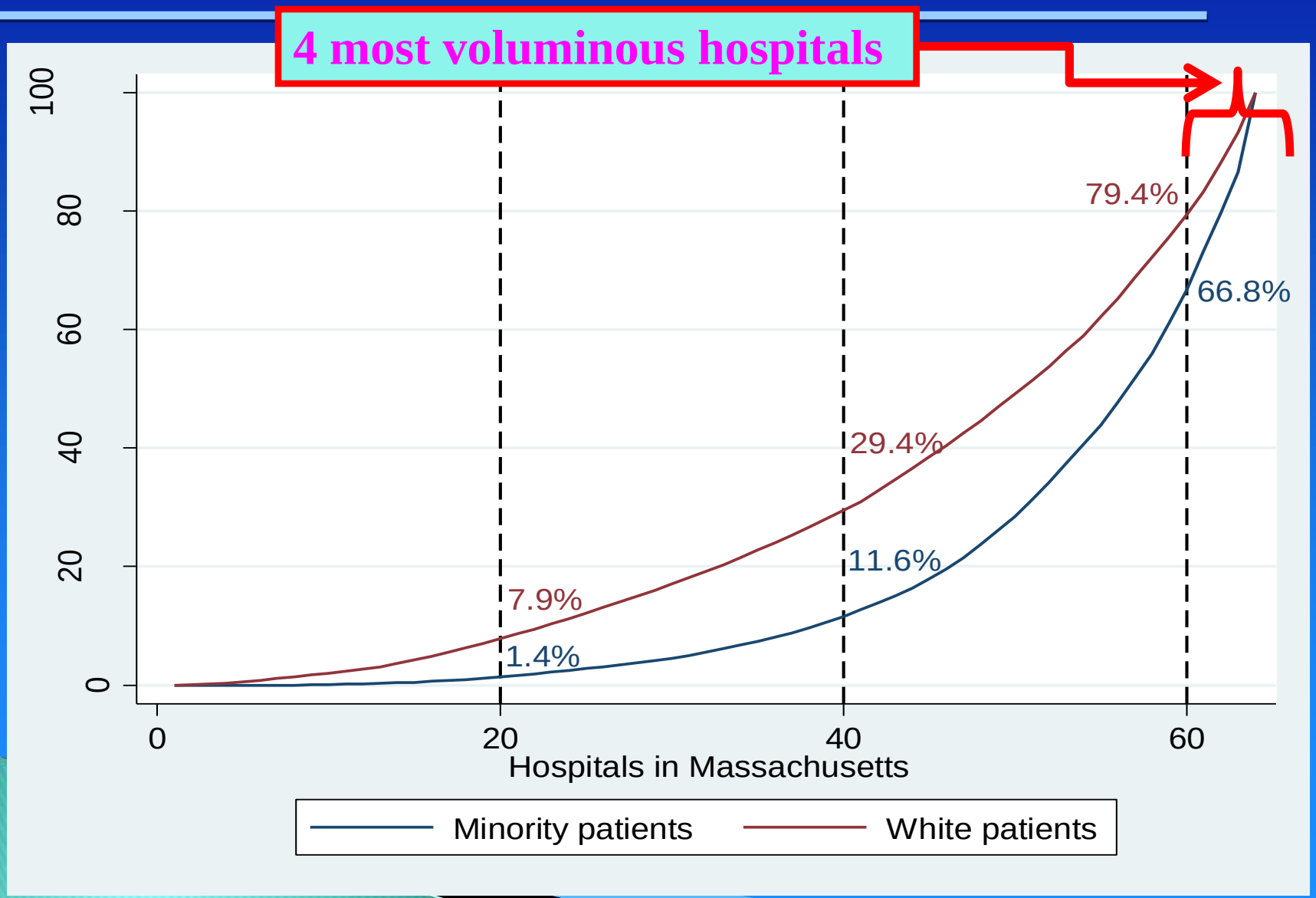
* Cultural Competence Organizational Self-Assessment (CCOSA)

Financial Incentives

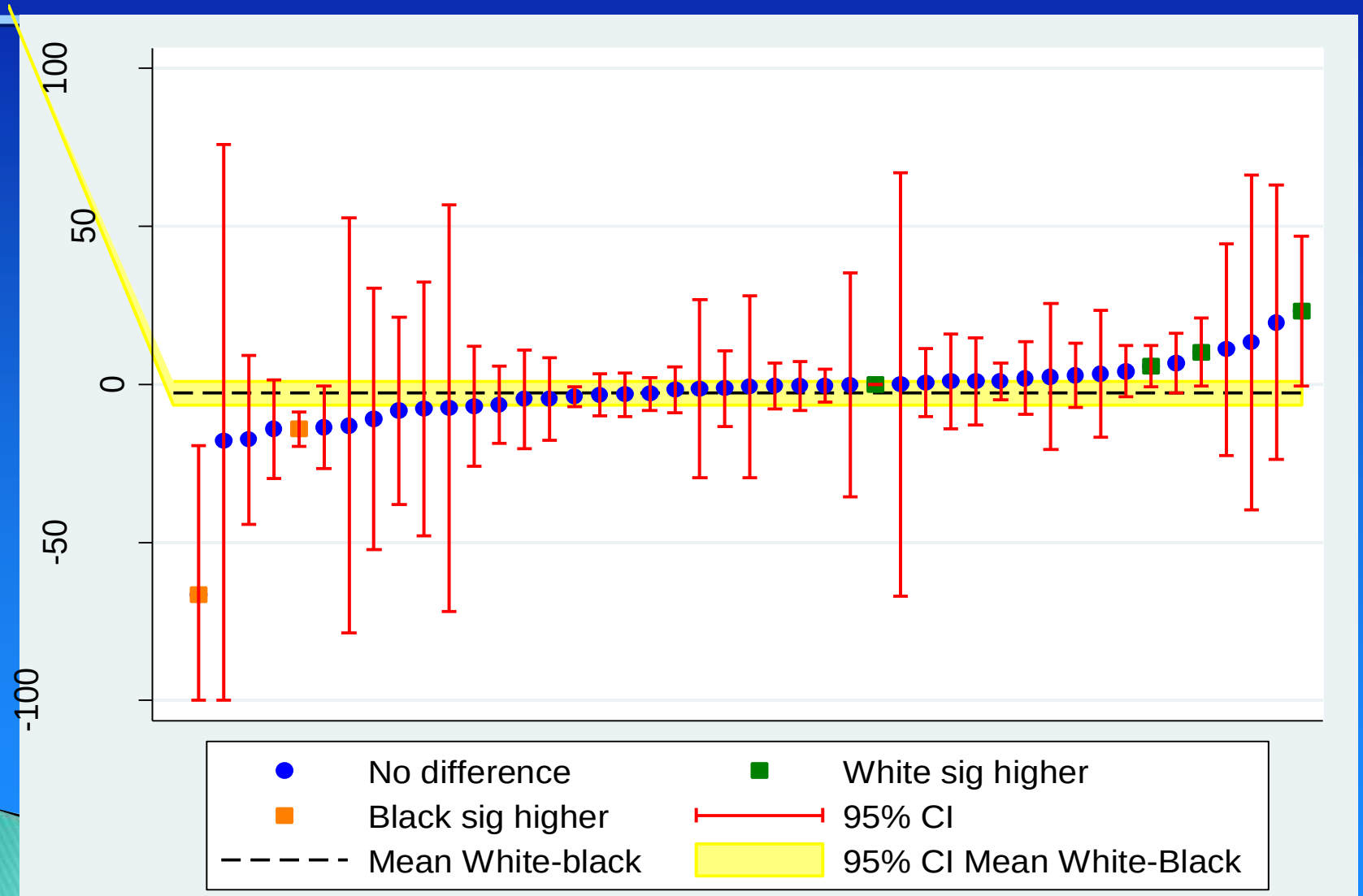
- Rate Year [RY] 2008
  - $4.5M was allocated for payments for performance on the structural measures;
- By RY 2010, this was set to increase to $20M for performance on the structural measures and $12M for disparities on the clinical measures.
  - >$300,000 per hospital for the structural measures, >$180,000 per hospital for the clinical measures.
  - Compare with Premier Hospital Quality Incentive Demonstration = ~$33,000 per hospital per year from 2003 through 2006

FINDINGS

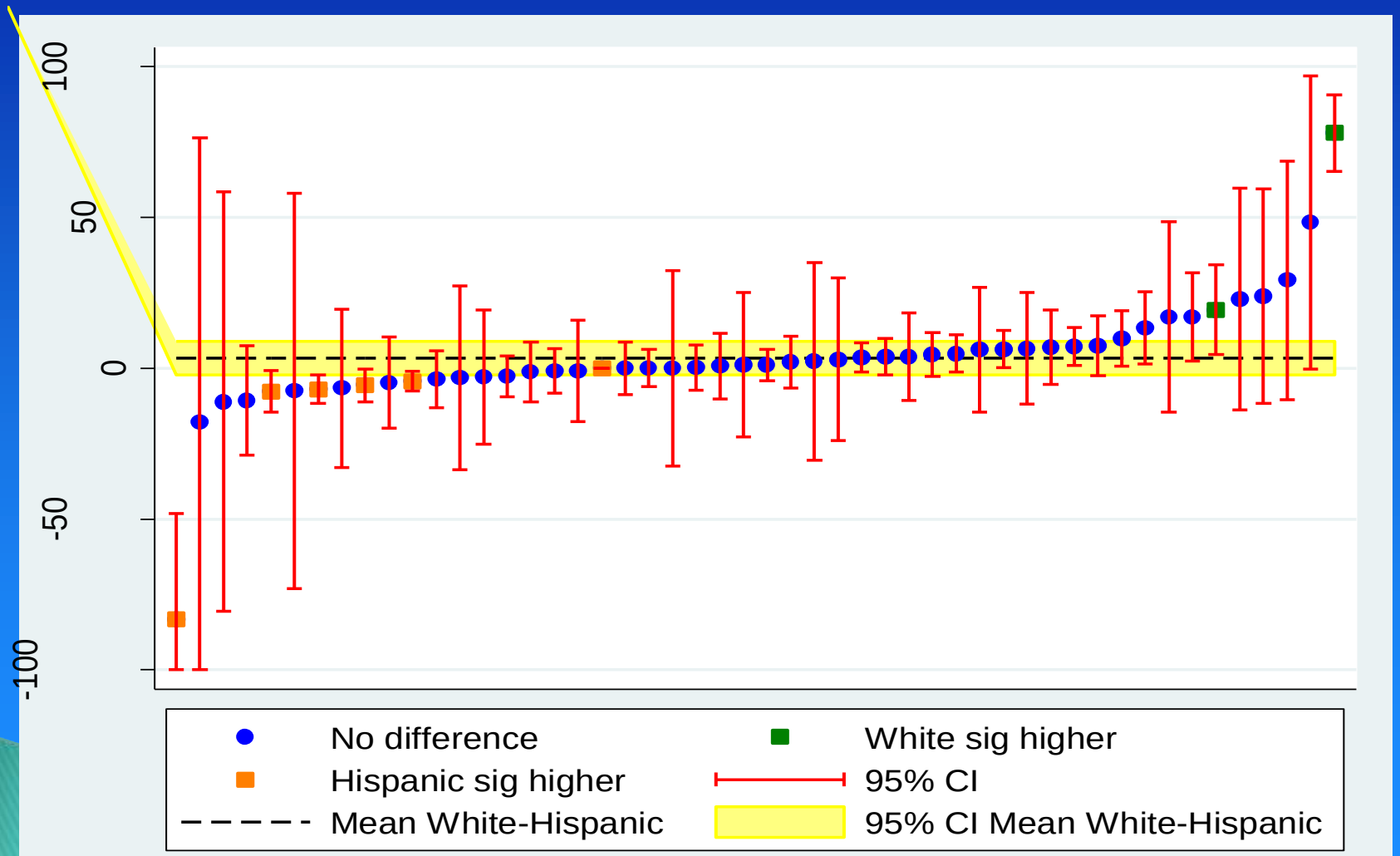
Care of minorities is relatively concentrated compared with whites



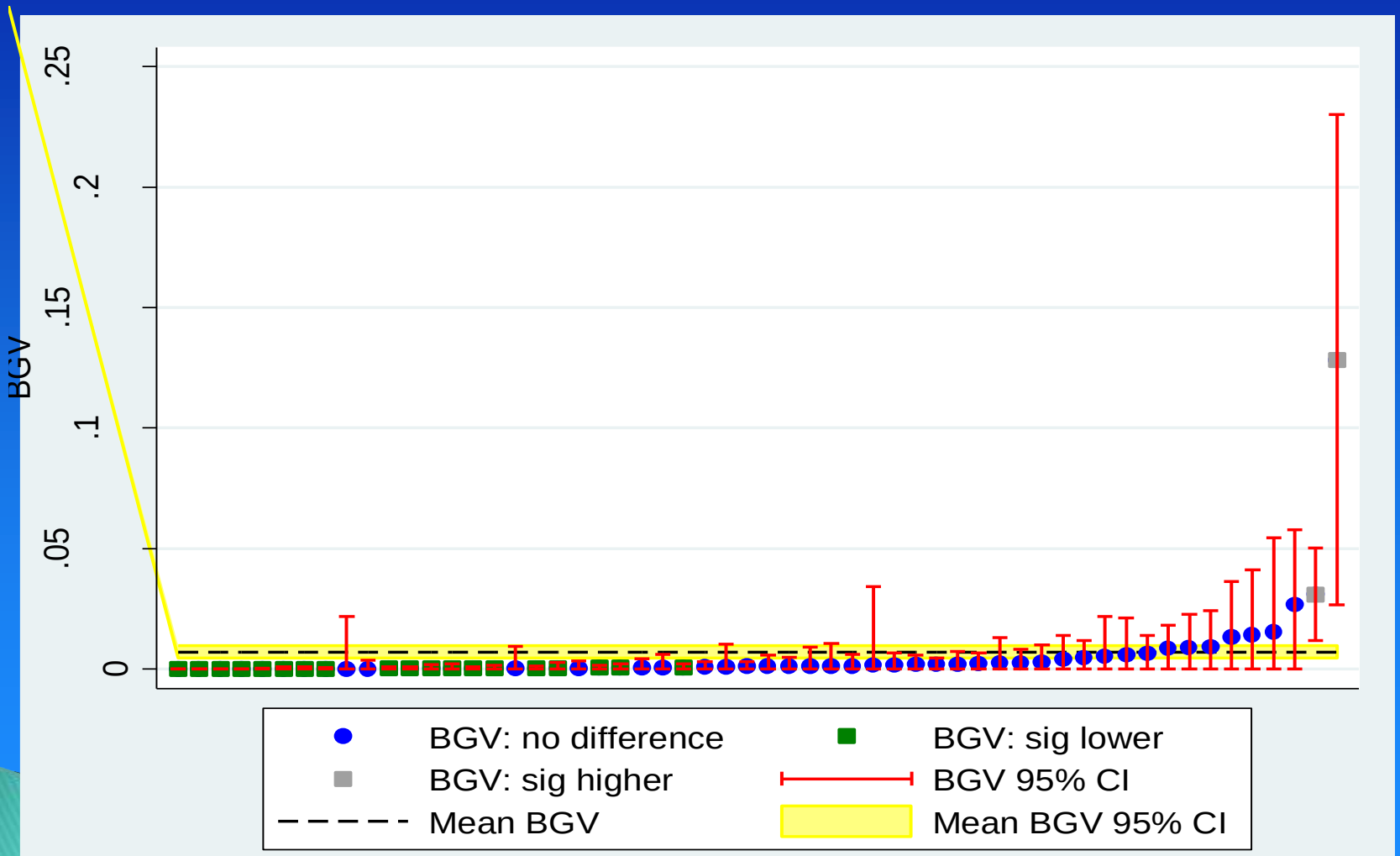
Hospital-level Absolute Risk Differences (ARDs): White minus Black, RY 2009



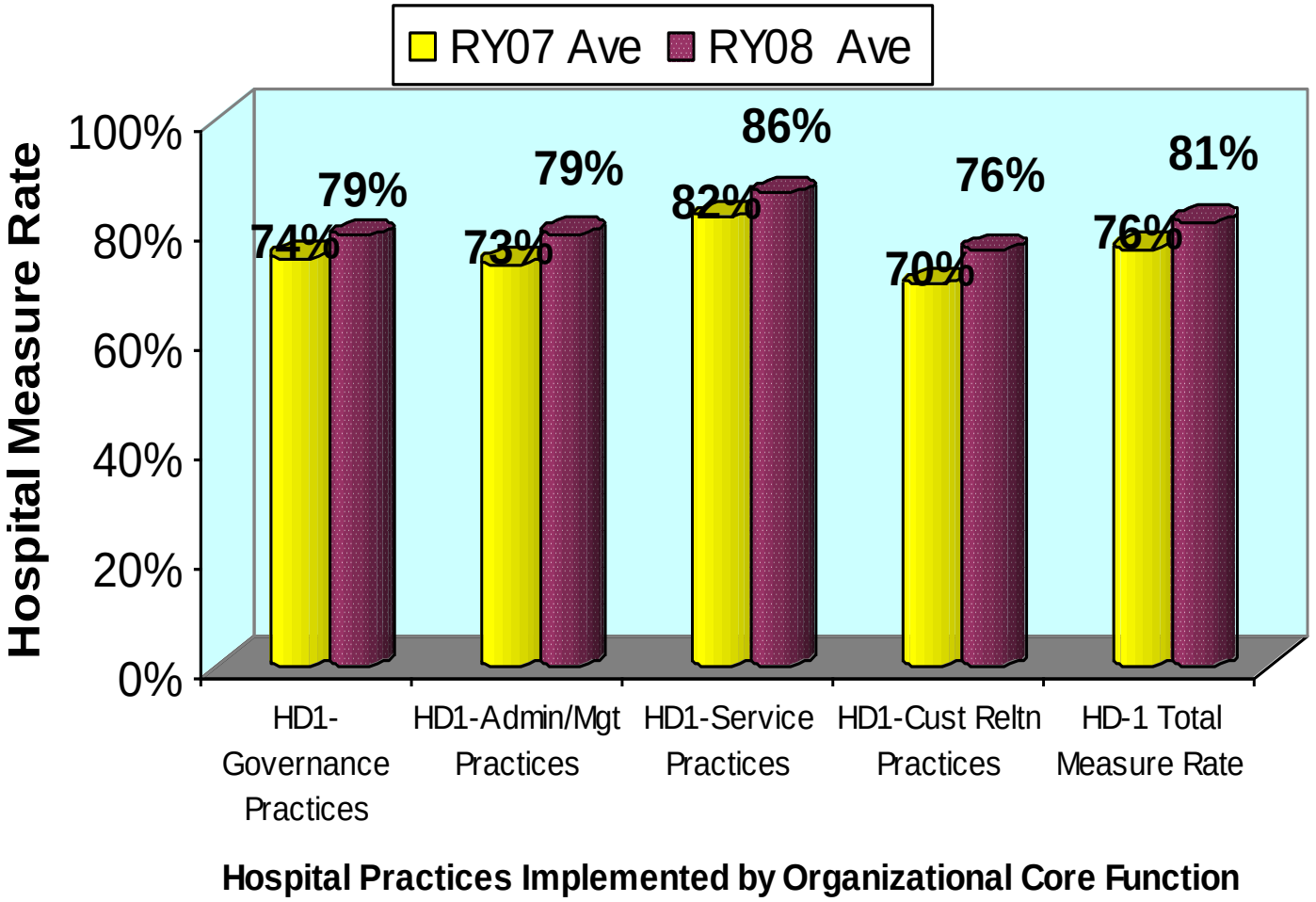
Hospital-level Absolute Risk Differences (ARDs): White minus Latino, RY 2009



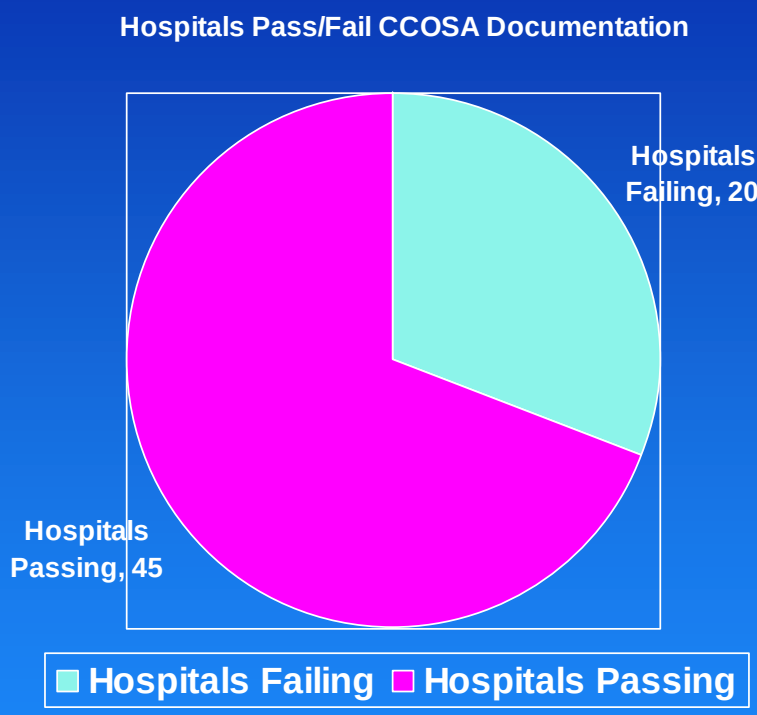
Hospital-level Between Group Variance (BGV) Values



RY08 CLAS Measure Rate Results



Mixed Reactions from Hospital Community



- Strong stated support for the program's goal
- Participation required extraordinary effort
- Frustration with the effort required to adapt to the clinical reporting system
- CCOSA* checklist felt to be "ambiguous"
- Perceived focus on documentation at the expense of quality improvement

* Cultural Competence Organizational Self-Assessment (CCOSA)

Lessons

- Context Matters
- Sample size problems should be addressed up front
- Disparities indicators may need to be re-considered after examining the data
- Complex questions elicit nuanced answers
- The “between” problem should be examined along with the “within” problem.

Acknowledgements

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“In order to eliminate disparities in health, we need leaders who care enough, know enough, will do enough and are persistent enough.”

- David Satcher, M.D., Ph.D.
- Former Surgeon General of the U.S.

End of Presentation

Extra Unused Slides Follow

{I probably will not keep this slide}Health Disparities Measurement & Incentive Strategy

Strategy	RFA08 (Yr.1) HD-1 Structural Measure	RFA09 (Yr. 2) HD-2 Clinical Measures
Overall Approach	■ Reward Hospitals to improve organizational factors that reduce racial/ethnic health disparities.	■ Reward Hospitals to report data by Race/Ethnicity & reduce disparities in clinical quality measures
Performance Measure	■ Require Hospitals to implement CLAS standards regardless of patient R/E/L mix served.	Clinical Quality Measures: ■ Maternity/Newborn indicators ■ Pediatric Asthma indicators ■ Pneumonia indicators ■ Surgical Infxn Prevention indicators
Performance Assessment Method	■ CLAS Validation Rate ■ CLAS Best Practice Rating ■ CLAS Measure Score	▪Data Validation Rate (RY09) ▪Clinical Disparity Measure Score (RY2010)
Bonus Payment Approach	■ Earn payments for meeting performance thresholds on organizational factors (implementing CLAS).	■ Earn payments for meeting performance thresholds on clinical disparities measures

MassHealth Acute Hospital Clinical Quality Measures Set*

MATERNITY & NEWBORN	PEDIATRIC ASTHMA	SURGICAL INFECTION PREVENTION	COMMUNITY ACQUIRED PNEUMONIA	HEALTH DISPARITIES
MAT-1: Intrapartum Antibiotic prophylaxis for Group B Streptococcus	**CAC-1:** Children's Asthma Care - Inpatient use of relievers	**SCIP-1a:** Prophylactic Antibiotic w/in 1hr prior to surgical incision	**PN-1:** Oxygenation Assessment **(RETIRED)**	**HD-1:** (RY09+RY10) Cultural & Linguistic Appropriate Service (CLAS) Standards
MAT-2: Perioperative Antibiotics for Cesarean section	**CAC-2**: Children's Asthma Care - Inpatient use of Corticosteroids	**SCIP-2a:** Appropriate Antibiotic selection for surgical prophylaxis	**PN-3b**:Blood culture performed in ED prior to first antibiotic rec'd in hospital	**HD-2**: (P4R in RY09) Clinical Health Disparities
NICU-1: Neonatal Intensive Care - Administration of Antenatal steroids	CAC-3: Children's Asthma Care - Home Mgt. Plan of Care **(NEW in RY10)**	**SCIP-3a:** Prophylactic Antibiotic discont. w/in 24 hrs after surgery end time	**PN-4:** Adult smoking cessation advice & counseling	**HD-2**: (P4P in RY10) Clinical Health Disparities **(PHASE-IN)**
			PN-5c:Initial Antibiotic received within 6 hrs of arrival	
			PN-6: Appropriate Antibiotic selection for immuno-competent patients	

Care of Minorities is Concentrated

Jan/Andy – Any chance we could make a graph out of this, e.g., a cumulative distribution graph? y access = % of care; x access = number of hospitals

From text:
…2/3 of the opportunities from African-American patients emanated from 10 hospitals; 89% came from 20 hospitals; and 96% came from 30 hospitals. Similarly, for Latino patients, 2/3 of the opportunities emanated from just 10 hospitals; 88% came from 20 hospitals, and 95% came from 30 hospitals. In contrast, for white patients 40% of opportunities came from 10 hospitals, 63% came from 20 hospitals, and 79% came from 30 hospitals. Eight of the state's hospitals reported zero opportunities for non-white patients.

Care of minorities relatively concentrated

- Blacks
  - 66% of opportunities from 10 hospitals
  - 89% of opportunities from 20 hospitals
- Hispanics
  - 66% from 10 hospitals;
  - 88% from 20 hospitals
- Whites
  - 40% from 10 hospitals,
  - 63% from 20 hospitals